CTR Counselor Number Request Form

COUNSELOR INFORMATION

Counselor Name: _____

Social Security number: ____ ____ ____ - ____ ____ - ____ ____ ____ ____

STD PROGRAM/DOC ASSIGNED NUMBER (if applicable): _____

Date Level I HIV Counselor Training Completed:_____

PROFESSION: (check one)

RN ___ SW ___ Counselor ____ DIS ____ MD ____ PA ____ NP ____ Other ___

Local Health Department/
Organization/Agency:_____

Program/Clinic: _____

Site # _____

Address:_____
_____
_____

Counselor phone number: _____

SUPERVISOR INFORMATION

Supervisor of Counselor:_____
Phone number: _____
Fax number:_____

Please submit completed form to: Sandra L. Offerman
AIDS Administration
500 N. Calvert Street, 5th Floor
Baltimore, MD 21202
Phone: (410) 767-5018 Fax: (410) 333-4805

FOR AIDS ADMINISTRATION USE ONLY

Counselor # issued: _____ Date issued _____